

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13780

CERTIFICATE OF DEATH

13783

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		c. LENGTH OF STAY IN 1b 19 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PHYSICIANS MEMORIAL HOSP.		d. STREET ADDRESS RE 1 Box 385	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cecil Gilbert Aleshire		4. DATE OF DEATH October 22 19 67	
5. SEX Male		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 3, 1904	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY SELF Employed	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARTIN L. ALESHIRE		14. MOTHER'S MAIDEN NAME ZORA B. STONEBURGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577-168653	
17. INFORMANT MRS. DONALD CHEVILLE		Address 4902 HARVEST RD. WASH. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Hypertroid degeneration DUE TO (c) Arteriosclerotic Cardio-Renal disease		INTERVAL BETWEEN ONSET AND DEATH 3 day 3 wks 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 Oct 1967 , to 22 Oct 19 67 that (I) (we) last saw the deceased alive on 22 Oct 1967 , and that death occurred at 9:55 P.M. from causes and on the date stated above.			
22a. SIGNATURE Mr Wooddy		22b. DATE SIGNED 23 Oct 67	
22c. PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY MD		22d. ADDRESS La Plata Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-25-67	
23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City or town) (County) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR The HUNT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR DATE OCT 26 1967	
25b. REGISTRAR'S SIGNATURE William J. Jones			

1900

THE UNIVERSITY OF CHICAGO

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THE UNIVERSITY OF CHICAGO
CHICAGO, ILL.
JANUARY 1, 1900
TO THE PRESIDENT OF THE UNIVERSITY
FROM THE FACULTY
The Faculty of the University of Chicago
has the honor to acknowledge the receipt
of your letter of the 28th inst. and
to express its appreciation of the
interest which you have taken in
the work of the University.
The Faculty is deeply indebted to you
for the many ways in which you have
promoted the welfare of the University
and for the many suggestions which
you have made for its improvement.
The Faculty is confident that the
University will continue to grow and
develop under your leadership and
that it will be able to maintain its
position as one of the leading
universities of the world.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.
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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13781

13784

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b D202A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital		d. STREET ADDRESS Rock Point	
3. NAME OF DECEASED (Type or print) STERLING		4. DATE OF DEATH October 3, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1912
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Bailey		14. MOTHER'S MAIDEN NAME Nettie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-16-3997	
17. INFORMANT Mrs. Alberta M. Bailey-Wife Md.		Address Rock Point,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) E.J. Edelen, M.D. La Plata, Md.		22. DATE SIGNED 10-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/5/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery	23d. LOCATION (City or Town) (County) (State) Issue, Maryland
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR OCT 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13785													
Item #8 Film #G393 10/10/67 pp													
1. PLACE OF DEATH a. COUNTY <u>Charles County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> d. STREET ADDRESS <u>Rt. 1-Box 256</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L.</u> Last <u>Booth</u>						4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899</u> <u>4-5-1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Charles Co. Maryland</u>			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>George L. Booth</u>						14. MOTHER'S MAIDEN NAME <u>Nellie Steward</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Julie Jenifer</u> Address <u>Rt. 1-Box 258 Waldorf, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>0021 Congestive heart failure Acute Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Pulmonary Tuberculosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>12 mo.</u> <u>Years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this-hospital) attended the deceased from <u>2/8</u> , 19 <u>67</u> , to <u>10/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/24</u> , 19 <u>67</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.													
22a. SIGNATURE <u>Thomas L. Fieldson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED <u>2 Oct 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas L. Fieldson M.D.</u>										22d. ADDRESS <u>Brandywine, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 4-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Ch. Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Bryantown Chas. Co. Md.</u>						
24. FUNERAL DIRECTOR <u>Martell Adams</u> ADDRESS <u>Aguasco, Md.</u>						25a. REC'D BY REGISTRAR <u>OCT 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>					

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13783

13787

FOR STATE
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND Florida Dade Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg Miami (33157)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) White House Motel		d. STREET ADDRESS 11221 S.W. 180th. Street	
3. NAME OF DECEASED (Type or print) JACK JAMESON FETTERLY		4. DATE OF DEATH Month October Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF, M/Sgt. Ret.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 53
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Francis Fetterly		14. MOTHER'S MAIDEN NAME Amie Jameson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII & Korea		16. SOCIAL SECURITY NO. 286-01-0931	
17. INFORMANT Margaret Lee Fetterly-Wife		11221 S.W. 180th. St. Miami, Fla.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact gunshot wound of abdomen DUE TO (b) 976x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self	
20c. TIME OF INJURY Month, Day, Year approx 1:00 p.m. 10-10 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) motel	20f. (City or town) (County) (State) Newburg, Charles Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) October 10, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		22. DATE SIGNED October 10, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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FOR STATE HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13784

13788

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. LENGTH OF STAY IN lb Ripley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital (DOA)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARK STAFFORD GELZER		4. DATE OF DEATH Pronounced October 7 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1967
9. AGE (In years last birthday) 9 wks. 2		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gelzer		14. MOTHER'S MAIDEN NAME Bonita Klaas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John Gelzer-Father Box 281		Address Indian Head, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 525 x Interstitial pneumonitis (SDII) IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/9/1967	
23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Waldorf, Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR OCT 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judar		22. DATE SIGNED 10-7-67	

1278

UNITED STATES DEPARTMENT OF JUSTICE

1278

Washington

May 1941

Chicago

Chicago

Chicago

Re Chicago letter of May 1, 1941

Enclosed

Chicago

Chicago

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago

Chicago

Chicago, May 1, 1941

1278

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago, May 1, 1941

Chicago, May 1, 1941

13785

CERTIFICATE OF DEATH

13789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Charles MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown La Plata		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS Bryantown	
3. NAME OF DECEASED (Type or print) First Middle Last Lillian M. Greene		4 DATE OF DEATH Month Day Year October 24, 1967	
5 SEX Female	6 COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-11-30
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Joseph Edelen		14. MOTHER'S MAIDEN NAME Mary C. Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Paul E. Green Bryantown P.O. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. DUE TO (b) Hypertension DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Not known
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 23 , 19 67 , to Oct. 24 , 19 67 , that (I) (we) last saw the deceased alive on Oct. 24 , 19 67 and that death occurred at 6:14 A.M. from causes and on the date stated above.			
22a. SIGNATURE Arturo M. Monteiro		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type) Arturo M. Monteiro		22d. ADDRESS La Plata, Charles MD	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Church Cem. Bryantown Chas. Co. Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Martell Adams Ciguasco Md.		25a. REC'D BY REGISTRAR DATE NOV 2 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11 & 12 Film #3394 11/2/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13786

13790

1 PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE <u>Me</u> b. COUNTY <u>Ches</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY in 1b <u>13 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
3 NAME OF DECEASED (Type or print) <u>Mary Jane Greene</u>				d. STREET ADDRESS <u>515 D St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <u>Mary Jane Greene</u>		4 DATE OF DEATH <u>10 29 67</u>		5 SEX <u>F</u>		6 COLOR OR RACE <u>C</u>	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>3-2-35</u>		9 AGE (In years last birthday) <u>32</u>		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Charles Co, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Frank Diggs</u>				14 MOTHER'S MAIDEN NAME <u>MANDY Diggs</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT <u>William Diggs</u> Address <u>515 D St</u>		18 INTERVAL BETWEEN ONSET AND DEATH <u>6/10 10-29-67</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>P.V.H.</u> (b) <u>Legs are blue</u> (c) <u>Senile atrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>F. J. Edelen</u> M.D.				22. DATE SIGNED <u>10-29-67</u>			
EXAMINER'S NAME (Type) <u>F. J. Edelen</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/2/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Ironsides Charles Co Md</u>	
24. FUNERAL DIRECTOR <u>Montgomery Bros Inc</u> ADDRESS <u>719 Kennedy St NW Washington D.C.</u>				25a. REC'D BY REGISTRAR <u>OCT 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Richard J. ...</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

13787

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13791

1 PLACE OF DEATH a. COUNTY Charles MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		e. STREET ADDRESS Issue/ Tompkinsville (Rural)	
3 NAME OF DECEASED (Type or print) First Middle Last LOUIS LENZY OLIVER		4 DATE OF DEATH Month Day Year October 15, 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 5, 1927 9 AGE (n years last birthday) 40 Yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11 BIRTHPLACE (State or foreign country) St. Mary's Co., Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lester G. Oliver		14. MOTHER'S MAIDEN NAME Sarah E. Chinn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO YES (UNKNOWN)	
17 INFORMANT Mrs. Mazie Ann Oliver-Wife		18. Tompkinsville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) 4221 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 10/16/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/18/1967	
23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City or Town) (County) (State) Wayside, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR OCT 19 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) LaPlata		c. LENGTH OF STAY IN 1b Forrest Heights		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 163 Forrest Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital		d. STREET ADDRESS 414 Quade Street		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES BYRON PARNELL		4 DATE OF DEATH Month October Day 14 Year 19 67		5 AGE (in years lost birthday) 46 yrs.	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-29-1921	9 UNDER 1 YEAR Months 46 Days 46 Hours 46 Min. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Lake City, Florida		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Byron English Parnell		14. MOTHER'S MAIDEN NAME Alberta M.		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	
16 SOCIAL SECURITY NO. 266-22-4748		17 INFORMANT Ida V. Parnell Same as # 2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 783 X IMMEDIATE CAUSE (a) Traumatic Subarachnoid Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) Blow on head with Que Stick			
20c. TIME OF INJURY Month, Day, Year Hour 7:15 p.m. 10/14 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Restaurant	
20e. CITY OR TOWN Charles, Md.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 10/16/67		22. DATE SIGNED	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-19-1967	
23c. NAME OF CEMETERY OR CREMATORY Grant Church		23d. LOCATION (City or Town) (County) (State) Westmoreland County, Va		23e. REC'D BY REG. STRAR OCT 19 1967	
24. FUNERAL DIRECTOR Robert A. Mattingly		25a. ADDRESS 131 11th St S.E. Wash 3, DC		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 13793											
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LA PLATA c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PHYSICIANS MEMORIAL HOSP.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WALDORF d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WOODROW WILSON PARSONS First Middle Last 4. DATE OF DEATH OCT. 22, 1967 Month Day Year						5. SEX MALE 6. COLOR OR RACE CAV. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH JULY 2, 1912 9. AGE (in years last birthday) 55 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED				10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) CHARLES MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JULIAN W. PARSONS						14. MOTHER'S MAIDEN NAME BELLE LYNCH PARSONS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 216-18-0325		17. INFORMANT FREDERICK PARSONS, WALDORF, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) Simple Coronary Artery Atherosclerosis DUE TO (c) aging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 day year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 10-12 , 19 64 , to 10-22 , 19 67 , that (I) (we) last saw the deceased alive on 10-21 19 67 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Richard Dobson 22c. PHYSICIAN'S NAME (Type) RICHARD DOBSON										22b. DATE SIGNED 10-22-67 22d. ADDRESS BRANDYWINE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10-25-67		23c. NAME OF CEMETERY OR CREMATORY TRINITY MEMORIAL		23d. LOCATION (City, town or county) (State) WALDORF MD.			
24. FUNERAL DIRECTOR HUNTT FUNERAL HOME, WALDORF, MD.						25a. REC'D BY REGISTRAR OCT 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13794

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton c. LENGTH OF STAY IN Td 2-Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata d. STREET ADDRESS Route #3 e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Allen Leo Pickeral		4. DATE OF DEATH Month 10 Day 24 Year 67	
5. SEX Male	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1917 9. AGE (in years last birthday) 50 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired - Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Pickeral		14. MOTHER'S MAIDEN NAME Annie Pickeral	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). (If yes, give war or dates of service) Yes WWII US Army Dis		16. SOCIAL SECURITY NO 577-22-4492	17. INFORMANT Mother-Annie Pickeral LaPlata Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion-Massive DUE TO (b) Arterio-Sclerosis General DUE TO (c) Severe Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Immediate Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COME ON GIVEN IN PART I (a) Severe Emphysema			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James E. Andrews MD EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Indian Head Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Charles</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Charles</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>						c. LENGTH OF STAY IN 1b <u>Physicians Memorial Hosp.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Elmer G. Reich</u>						4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1967</u>							
5. SEX <u>F</u>						6. COLOR OR RACE <u>Caucasian</u>							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Feb. 14, 1884</u>							
9. AGE (In years last birthday) <u>83 yrs.</u>						10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher Public Schools</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Frederick Co. Md.</u>							
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>						12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>John Graham Johnson</u>						14. MOTHER'S MAIDEN NAME <u>Eleanor Sanderson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>L.T. Johnson</u>							
17. INFORMANT <u>Address 1000 Broadmore Cir Silver Springs Md.</u>													
18. CAUSE OF DEATH [Enter only one cause per item for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(adenocarcinoma) descending colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Colorectal</u> (c) <u>4 mos.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>10-2-67</u> to <u>10-2-67</u> , that (I) (we) last saw the deceased alive on <u>10-2-67</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Edelen</u>						22b. DATE SIGNED <u>10-5-67</u>							
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Edelen</u>						22d. ADDRESS <u>La Plata, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>						23b. DATE THEREOF <u>10-7-67</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>						23d. LOCATION (city, town or county) (State) <u>Frederick Md.</u>							
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md.</u>						25a. REC'D BY REGISTRAR <u>Oct 11 1967</u>							
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 M
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13792

CERTIFICATE OF DEATH

13796

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Tobacco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Havre De Venture Farm		d. STREET ADDRESS Havre De Venture Farm	
3. NAME OF DECEASED (Type or print) First Peter Middle Vischer Last Vischer		4. DATE OF DEATH Month October Day 25 Year 1967	
5. SEX male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1898
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 29 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Writer-Reporter		10b. KIND OF BUSINESS OR INDUSTRY Newspapers	
11. BIRTHPLACE (County & State, or foreign country) New York, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Vischer		14. MOTHER'S MAIDEN NAME Sophie Schneider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Helen Vischer - Port Tobacco, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August , 1962, to October , 1967, that (I) was saw the deceased alive on 2504 1967, and that death occurred at 5:00 PM , from causes and on the date stated above.			
22a. SIGNATURE J. Barry Mason M.D.		22b. DATE SIGNED 25 Oct 67	
22c. PHYSICIAN'S NAME (Type) J.B. Barry Mason, M.D.		22d. ADDRESS La Plata, Md. 20646	
23a. BURIAL, CREMATION, REBURYING, etc. Cremation	23b. DATE THEREOF 10/26/1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. - La Plata, Md.		25a. REC'D BY REGISTRAR OCT 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

3252

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13792

13797

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palomares River</u>		c. LENGTH OF STAY IN 1b <u>1 hr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Near Issue, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest BARKSDALE</u>		DATE OF DEATH <u>10-1-67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-46</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Monticello Dairy</u>	
13. FATHER'S NAME <u>Ernest B. Wells, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Janice M. McMurdie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hill & Irving Funeral Home</u>		Address <u>Charlottesville, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Left a sinking boat -</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Palomares River</u>	20f. (City or town) (County) (State) <u>Charlottesville, Va.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.		22. DATE SIGNED <u>10-5-67</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		Address <u>La Plata, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monticello Mem. Park</u>	23d. LOCATION (City or town) (County) (State) <u>Charlottesville, Va.</u>
24. FUNERAL DIRECTOR <u>Hill & Irving Funeral Home, Charlottesville</u>		25. REC'D BY REGISTRAR <u>Oct 10 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

Arehart Funeral Home, Inc., La Plata, Md. Va.

1. The first part of the report is a general
 description of the area. It is a large area
 of land, mostly flat, with some hills in the
 north. The climate is warm and humid, with
 a lot of rain. The population is small, but
 growing. The economy is based on agriculture,
 mostly rice and rubber. There are some
 small towns and villages, but no big cities.

2. The second part of the report is a
 description of the land. It is mostly flat,
 with some hills in the north. The soil is
 mostly red, but there are some areas of
 black soil. The land is mostly used for
 agriculture, mostly rice and rubber. There
 are some small towns and villages, but no
 big cities. The population is small, but
 growing. The economy is based on agriculture,
 mostly rice and rubber.

3. The third part of the report is a
 description of the people. They are mostly
 of Chinese descent, but there are some
 other groups. They speak Chinese, but
 there are some local dialects. They are
 mostly farmers, but there are some
 small businesses. They are mostly poor, but
 there are some rich people. They are
 mostly living in small towns and villages,
 but there are some big cities.

4. The fourth part of the report is a
 description of the government. It is a
 small government, with a few ministries.
 The president is the head of the government,
 and there are some ministers. The
 government is mostly responsible for
 agriculture, but there are some other
 departments. The government is mostly
 poor, but there are some rich people.